ICVH 2014

INTERATIONAL CONFERENCE ON VIRAL HEPATITIS

NEW YORK CITY • MARCH 17-18, 2014
Thank you for joining us for the 2014 International Conference on Viral Hepatitis.

We welcome you to a state-of-the-science forum at which we will examine sound and practical strategies to understand and enhance the clinical management of hepatitis B virus (HBV) and hepatitis C virus (HCV) infection.

There is clearly a need for this conference. We base this assertion on the rapid changes that are occurring in the science of viral hepatitis, and the multifaceted clinical and behavioral issues that hepatologists, gastroenterologists, and HIV-treating clinicians must understand in order to deliver quality HBV and HCV treatment.

This conference is an important forum to present the best evidence on HBV and HCV treatment, but the primary reason we come together is to rapidly translate these scientific advances into approaches that can make a difference in real-world settings.

We extend our gratitude to the conference’s Planning Committee, the International Association of Providers of AIDS Care (IAPAC), the Icahn School of Medicine at Mount Sinai’s Office of Continuing Medical Education, the International Association for the Study of the Liver (IASL), and the Association of Nurses in AIDS Care (ANAC). We also express our appreciation to our commercial supporters for their financial contributions. Finally, a special thank you to our distinguished faculty for what we are sure to be cutting-edge presentations to help advance our learning objectives.

Douglas T. Dieterich, MD
Course Director & Co-Chair

Mario U. Mondelli, MD, PhD
Co-Chair

Mark R. Nelson, MD
Co-Chair

1. Professor of Medicine, Icahn School of Medicine at Mount Sinai, New York, NY, USA
2. Professor of Infectious Diseases, University of Pavia, Pavia, Italy
3. Director of HIV Services, Chelsea & Westminster Hospital, London, England
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The 2014 International Conference on Viral Hepatitis is jointly sponsored by the Icahn School of Medicine at Mount Sinai and the International Association of Providers of AIDS Care (IAPAC), in partnership with the International Association for the Study of the Liver (IASL).

LEARNING OBJECTIVES
After attending this activity, the participant will demonstrate the ability to:

- Describe strategies for viral hepatitis diagnosis and linkages to evidence-based treatment
- Define the characteristics and recommended use of approved agents for the management of viral hepatitis
- Identify treatment options for patients who present with viral hepatitis, including interventions to promote treatment success
- Discuss the management of complications due to viral hepatitis, its treatment, and/or comorbidities
- Explore ways to expand the categories of clinicians engaged in viral hepatitis management, including nurses/nurse-practitioners, psychologists, and pharmacists in a variety of practice settings, including primary care

TARGET AUDIENCE
This activity has been designed for gastroenterologists, hepatologists, and infectious disease (ID) and non-ID-specialized physicians, nurses/nurse-practitioners, physician assistants, and pharmacists involved (or soon to be involved) in the diagnosis and active management of patients with HBV or HCV infection.

The Icahn School of Medicine at Mount Sinai takes responsibility for the content, quality, and scientific integrity of this continuing medical education (CME) activity.

PHYSICIAN ACCREDITATION STATEMENT
This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education, through the joint sponsorship of the Icahn School of Medicine at Mount Sinai and IAPAC. The Icahn School of Medicine at Mount Sinai is accredited by the ACCME to provide continuing medical education for physicians.

CREDIT DESIGNATION STATEMENT
The Icahn School of Medicine at Mount Sinai designates this live activity for a maximum of 13 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in this activity.

COPYRIGHT INFORMATION
All rights reserved. No part of this syllabus may be used or reproduced in any manner whatsoever without written permission except in the case of brief quotations embodied in articles or reviews.

FACULTY DISCLOSURE
It is the policy of the Icahn School of Medicine at Mount Sinai that the faculty and provider disclose real or apparent conflict of interest relating to the topics of this educational activity, and also disclose discussions of unlabeled/unapproved uses of drugs or devices during their presentation(s). Detailed disclosure will be made in the conference handout materials.

DISCLAIMER STATEMENT
The opinions and recommendations expressed by faculty and other experts whose input is included in this activity are their own. Use of the Icahn School of Medicine at Mount Sinai name implies review of educational format design and approach.

NOTICE ABOUT OFF-LABEL USE PRESENTATIONS
The 2014 International Conference on Viral Hepatitis may include presentations on drugs or devices, or use of drugs or devices that have not been approved by the Food and Drug Administration (FDA) or have been approved by the FDA for specific uses only. The FDA has stated that it is the responsibility of the physician to determine the FDA clearance status of each drug or device he or she wishes to use in clinical practice.

The Icahn School of Medicine at Mount Sinai is committed to the free exchange of medical education. Inclusion of any presentation in this activity, including presentations on off-label uses, does not imply an endorsement by the Icahn School of Medicine at Mount Sinai of the uses, products, or techniques presented.

AMERICANS WITH DISABILITIES ACT
IAPAC and the Icahn School of Medicine at Mount Sinai are in full compliance with provisions of the Americans with Disabilities Act (ADA) and the conference is accessible for individuals with special needs. Please notify us if you have any special needs.
ACCREDITATION INFORMATION

VERIFICATION OF ATTENDANCE
Physicians: CME certificates will be available for download 3 weeks after the conference. Please use the link and activity code below to download your CME Certificate.

www.mssm.edu/cme/courses
(Click on “Certificate” tab)
Activity Code - 105882

If you have any questions, please email the Icahn School of Medicine at Mount Sinai at cme@mssm.edu.

Nurse-Practitioners/Nurses: CE certificates will be provided to attendees by email three weeks after the conference.

If you have any questions, please email Angela Knudson, IAPAC’s Associate Director of Educational Programs, at aknudson@iapac.org.

SIGN-IN SHEET FOR ALL PARTICIPANTS
Please be sure to sign in each day to verify your attendance.

ACTIVITY EVALUATION
Activity evaluation will be conducted on-site. Attendees will be asked questions regarding attainment of objectives, effectiveness of faculty, objectivity, scientific integrity, and predictive change in behavior as a result of the intervention. In addition, participants will be asked to provide comments about the value of the activity as it relates to their professional experience.

POST-PROGRAM SURVEY
The post-program survey will include a combination of case vignettes and rating questions designed to assess learning retention, as well as changes in clinician knowledge, attitude, confidence, and performance that may have occurred as a result of participation in this activity. This survey will be conducted three months post-conference.

CME CONTACT INFORMATION
For CME questions, please contact the Icahn School of Medicine at Mount Sinai CME office:

Page and William Black Post-Graduate School
Icahn School of Medicine at Mount Sinai
One Gustave L. Levy Place-Box 1193
New York, NY 10029
Email: cme@mssm.edu
Phone: (212) 731-7950
Fax: (212) 731-7930

CONTINUING EDUCATION IN NURSING
The Association of Nurses in AIDS Care (ANAC) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

ANAC designates this educational activity for a maximum of 13.25 CNE contact hours.
FACULTY ROSTER

**COURSE DIRECTOR & CO-CHAIR**
Douglas T. Dieterich, MD
Icahn School of Medicine at Mount Sinai
New York, NY, USA

**CO-CHAIR**
Mario U. Mondelli, MD, PhD
University of Pavia
Pavia, Italy

**CO-CHAIR**
Mark R. Nelson, MD
Chelsea & Westminster Hospital
London, England

---

Kosh Agarwal, MD
King’s College Hospital
London, England

David J. Back, PhD
University of Liverpool
Liverpool, England

Sherilyn Brinkley, CRNP
Johns Hopkins University
Baltimore, MD, USA

Yvette Calderon, MD, MS
Albert Einstein College of Medicine
Bronx, NY, USA

Ivana Carey, MD, PhD
King’s College London
London, England

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New York, NY, USA

Alyson Harty, RN
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Ranjababu Kulasegaram, MD, FRC
Guy’s and St. Thomas’ NHS Foundation Trust
London, England

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New York, NY, USA

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The New York City Department of Health and Mental Hygiene
New York, NY, USA

Helen-Maria Lekas, PhD
Columbia University
New York, NY, USA

Jules Levin
National AIDS Treatment Advocacy Project
New York, NY, USA

Michelle T. Martin, PharmD, BCPS, BCACP
University of Illinois
Chicago, IL, USA

Natasha Martin, PhD
University of Bristol
Bristol, England

Thomas C.S. Martin, MS, MA, BMBC, MRCP
Chelsea & Westminster Hospital
London, England

Kiren Mitruka, MD, MPH
Centers for Disease Control and Prevention
Atlanta, GA, USA

Emma Page, MBBS, MRCP
Chelsea & Westminster Hospital
London, England

Massimo Puoti, MD
AO Ospedale Niguarda Cà Granda
Milan, Italy

K. Rajender Reddy, MD
University of Pennsylvania
Philadelphia, PA, USA

Sasan Roayaie, MD
Hofstra North Shore-LIJ School of Medicine
Manhasset, NY, USA

Alex Salam, MBChB, MSc, MRCP
Chelsea & Westminster Hospital
London, England

Gloria Searson, ACSW
Coalition on Positive Health Empowerment
New York, NY, USA

William Thompson
New York, NY, USA

Tram T. Tran, MD
Cedars-Sinai Medical Center
Los Angeles, CA, USA

Federico G. Villamil, MD
British Hospital of Buenos Aires
Buenos Aires, Argentina

Jeffrey Weiss, PhD
Icahn School of Medicine at Mount Sinai
New York, NY, USA

Benjamin Young, MD, PhD
International Association of Providers of AIDS Care
Washington, DC, USA
**FULL DISCLOSURE POLICY AFFECTING CME ACTIVITIES**

As a provider approved by the Accreditation Council for Continuing Medical Education (ACCME), it is the policy of the Icahn School of Medicine at Mount Sinai Office of Continuing Medical Education (OCME) to require signed disclosure of the existence of financial relationships with industry from any individual in a position to control the content of a CME activity sponsored by OCME. Members of the Planning Committee are required to disclose all relationships regardless of their relevance to the content of the activity. Speakers are required to disclose only those relationships that are relevant to their specific presentation. The following relationships have been reported for this activity:

<table>
<thead>
<tr>
<th>NAME AND LECTURE TITLE(S)</th>
<th>RELATIONSHIP(S)</th>
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<tbody>
<tr>
<td><strong>Kosh Agarwal, MD</strong></td>
<td>Consultant/Advisor: Astellas; Boehringer Ingelheim; Bristol-Myers Squibb; Gilead Sciences; Janssen Pharmaceuticals; Merck Sharpe &amp; Dohme; Novartis Pharmaceuticals.</td>
</tr>
<tr>
<td>Plenary 4: Recognizing Advanced Liver Disease for the New HCV Treater</td>
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<tr>
<td>Panel 2: Strengthening the HCV Continuum of Care</td>
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<tr>
<td><strong>David J. Back, PhD</strong></td>
<td>Consultant/Advisor: AbbVie; Boehringer Ingelheim; Gilead Sciences; Janssen Pharmaceuticals; Merck &amp; Co. Consulting Fees: AbbVie; Boehringer Ingelheim; Gilead Sciences; Janssen Pharmaceuticals; Merck &amp; Co. Honoraria: AbbVie; Boehringer Ingelheim; Gilead Sciences; Janssen Pharmaceuticals; Merck &amp; Co. Research Support: AbbVie; Boehringer Ingelheim; Gilead Sciences; Janssen Pharmaceuticals; Merck &amp; Co.</td>
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<tr>
<td>Plenary 8: Key Issues in Drug Interactions in the Direct-Acting Antiviral Era</td>
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<tr>
<td><strong>Sherilyn Brinkley, CRNP</strong></td>
<td>Advisory Board: AbbVie; Janssen Pharmaceuticals. Honoraria: Genentech; Gilead Sciences.</td>
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<tr>
<td>Panel 3: Managing Viral Hepatitis in Primary Health Care Settings and Exploring the Role of Non-Physician Clinicians</td>
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<tr>
<td><strong>Yvette Calderon, MD, MS</strong></td>
<td>Honoraria: Gilead Sciences; Merck &amp; Co.</td>
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<tr>
<td>Oral Abstract Session 2: Screening and Testing</td>
<td></td>
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<tr>
<td><strong>Ivana Carey, MD, PhD</strong></td>
<td>Research Support: Bristol-Myers Squibb; Gilead Sciences. Salaries/Officer’s Fees: Bristol-Myers Squibb.</td>
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<tr>
<td>Case Study Session: Vulnerable Populations</td>
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<tr>
<td><strong>Douglas T. Dieterich, MD</strong></td>
<td>Advisory Board: Boehringer Ingelheim; Bristol-Myers Squibb; Gilead Sciences. Consultant/Advisor: Boehringer Ingelheim; Bristol-Myers Squibb; Gilead Sciences. Consulting Fees: Boehringer Ingelheim; Bristol-Myers Squibb; Gilead Sciences. Honoraria: Boehringer Ingelheim; Bristol-Myers Squibb; Gilead Sciences.</td>
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<tr>
<td>Oral Abstract Session 4: Treatment Challenges</td>
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<td>Rapporteur Session: Bridging Barriers to Improve Viral Hepatitis Patient Outcomes in Diverse Communities and Populations</td>
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<tr>
<td><strong>Ranjababu Kulasegaram, MD, FRCP</strong></td>
<td>Consultant/Advisor: Boehringer Ingelheim; Bristol-Myers Squibb; Gilead Sciences; Johnson &amp; Johnson; Merck Sharpe &amp; Dohme; ViV Healthcare. Honoraria: Johnson &amp; Johnson; Merck Sharpe &amp; Dohme; ViV Healthcare.</td>
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<tr>
<td>Plenary 5: HIV Infection with HCV-Future Directions</td>
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<tr>
<td><strong>Natasha Martin, PhD</strong></td>
<td>Consulting Fees: Gilead Sciences. Honoraria: Janssen Pharmaceuticals.</td>
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<td>Panel 4: Reinfection: A Limiting Factor for HCV Treatment as Prevention?</td>
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<td>NAME AND LECTURE TITLE(S) (continued)</td>
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<tr>
<td><strong>Mark R. Nelson, MD</strong></td>
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<tr>
<td>Oral Abstract Session 1: Clinical Management</td>
<td>Advisory Board: Bristol-Myers Squibb; Gilead Sciences; Janssen Pharmaceuticals; Merck Sharpe &amp; Dohme; Roche Laboratories; ViV Healthcare. Consultant/Advisor: Boehringer Ingelheim; Bristol-Myers Squibb; Gilead Sciences; Janssen Pharmaceuticals; Merck Sharpe &amp; Dohme; Roche Laboratories; ViV Healthcare. Consulting Fees: Bristol-Myers Squibb; Gilead Sciences; Janssen Pharmaceuticals; Merck Sharpe &amp; Dohme; Roche Laboratories; ViV Healthcare. Research Support: Boehringer Ingelheim; Bristol-Myers Squibb; Gilead Sciences; Janssen Pharmaceuticals; Merck Sharpe &amp; Dohme; Roche Laboratories; ViV Healthcare.</td>
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<tr>
<td><strong>Massimo Puoti, MD</strong></td>
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<tr>
<td>Plenary 3: HCV State-of-the-Science</td>
<td>Advisory Board: AbbVie; Boehringer Ingelheim; Gilead Sciences; Janssen Pharmaceuticals; Merck Sharpe &amp; Dohme; Vertex Pharmaceuticals. Consulting Fees: Boehringer Ingelheim; Gilead Sciences; Janssen Pharmaceuticals; Merck Sharpe &amp; Dohme. Honoraria: Boehringer Ingelheim; Gilead Sciences; Janssen Pharmaceuticals; Merck Sharpe &amp; Dohme. Research Support: Bristol-Myers Squibb; Gilead Sciences; Merck Sharpe &amp; Dohme.</td>
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<tr>
<td><strong>K. Rajender Reddy, MD</strong></td>
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<tr>
<td>Plenary 7: Liver Transplant in HIV - Reopening the Debate</td>
<td>Consultant/Advisor: AbbVie; Bristol-Myers Squibb; Genentech; Gilead Sciences; Janssen Pharmaceuticals; Merck &amp; Co.; Vertex Pharmaceuticals. Research Support: AbbVie; Bristol-Myers Squibb; Genentech; Gilead Sciences; Janssen Pharmaceuticals; Merck &amp; Co.; Vertex Pharmaceuticals.</td>
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<tr>
<td><strong>Tram T. Tran, MD</strong></td>
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<tr>
<td>Plenary 10: Pregnancy and Hepatitis - An Underestimated Clinical Management Issue</td>
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<td><strong>Frederico G. Villamil, MD</strong></td>
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<tr>
<td>Panel 2: Strengthening the HCV Continuum of Care</td>
<td>Travel Grants: Gador S.A.; Genentech; Pfizer Inc.; Janssen Pharmaceuticals. Research Support: Janssen Pharmaceuticals.</td>
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<tr>
<td>Case Study Session: Complicated Cases</td>
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<tr>
<td><strong>Benjamin Young, MD, PhD</strong></td>
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No other speakers have indicated that they have any financial interests or relationships with a commercial entity whose products or services are relevant to the content of their presentation(s).
## ORAL ABSTRACT PRESENTERS

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<tr>
<td><strong>Jennifer Orsi, MPH</strong></td>
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<tr>
<td>54 - Patient Management Programs Lead to Improved Adherence for Patients with Hepatitis C using Drug Dual Therapy in Both Retail and Central Pharmacies</td>
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<tr>
<td><strong>Stacey Trooskin, MD, PhD</strong></td>
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No other oral abstract presenters have indicated that they have any financial interests or relationships with a commercial entity whose products or services are relevant to the content of their presentation(s).

## PLANNERS

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<tr>
<td><strong>Douglas T. Dieterich, MD</strong></td>
<td>Advisory Board: Boehinger Ingelheim; Bristol-Myers Squibb; Gilead Sciences. Consultant/Advisor: Boehinger Ingelheim; Bristol-Myers Squibb; Gilead Sciences. Consulting Fees: Boehinger Ingelheim; Bristol-Myers Squibb; Gilead Sciences. Honoraria: Boehinger Ingelheim; Bristol-Myers Squibb; Gilead Sciences. Research Support: Boehringer Ingelheim; Bristol-Myers Squibb; Gilead Sciences.</td>
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<tr>
<td><strong>Jeffrey Kwong, DNP, MPH, ANP-BC, ACRN</strong></td>
<td>No relevant financial interest or relationship with a commercial entity.</td>
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<tr>
<td><strong>Mario Mondelli, MD, PhD, FRCp</strong></td>
<td>No relevant financial interest or relationship with a commercial entity.</td>
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<tr>
<td><strong>Mark R. Nelson, MD</strong></td>
<td>Advisory Board: Bristol-Myers Squibb; Gilead Sciences; Janssen Pharmaceuticals; Merck Sharpe &amp; Dohme; Roche Laboratories; ViV Healthcare. Consultant/Advisor: Boehringer Ingelheim; Bristol-Myers Squibb; Gilead Sciences; Janssen Pharmaceuticals; Merck Sharpe &amp; Dohme; Roche Laboratories; ViV Healthcare. Consulting Fees: Bristol-Myers Squibb; Gilead Sciences; Janssen Pharmaceuticals; Merck Sharpe &amp; Dohme; Roche Laboratories; ViV Healthcare. Research Support: Boehringer Ingelheim; Bristol-Myers Squibb; Gilead Sciences; Janssen Pharmaceuticals; Merck Sharpe &amp; Dohme; Roche Laboratories; ViV Healthcare.</td>
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<tr>
<td><strong>Allison R. Webel, RN, BSN, MSN, PhD</strong></td>
<td>No relevant financial interest or relationship with a commercial entity.</td>
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<tr>
<td><strong>José M. Zuniga, PhD, MPH</strong></td>
<td>No relevant financial interest or relationship with a commercial entity.</td>
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**OFF-LABEL PRODUCT DISCUSSION**

The following speakers have disclosed that their presentation will reference unlabeled/unapproved uses of drugs or products.

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<tr>
<th>NAME AND LECTURE TITLE(S)</th>
<th>PRODUCT(S)</th>
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<tbody>
<tr>
<td>Kosh Agarwal, MD</td>
<td>ledipasvir, telaprevir, GS5186, GS-5885</td>
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<tr>
<td>Panel 2: Strengthening the HCV Continuum of Care</td>
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<tr>
<td>David Back, PhD</td>
<td>faldaprevir, daclatasvir</td>
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<tr>
<td>Plenary 8: Key Issues in Drug Interactions in the DAA Era</td>
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<tr>
<td>Michelle T. Martin, PharmD, BCPS, BCACP</td>
<td>NSSA protease inhibitors, NS5B polymerase inhibitor</td>
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<tr>
<td>Panel 3: Managing Viral Hepatitis in Primary Health Care Settings and Exploring the Role of Non-Physician Clinicians</td>
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<tr>
<td>Massimo Puoti, MD</td>
<td>ledipasvir, deleobuvir, faldaprevir, ABT 267, ABT 333, ABT450/r, daclatasvir</td>
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<td>Investigational HCV therapies</td>
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GENERAL INFORMATION

VENUE
The conference venue is Fordham University - Lincoln Center. The Plenary Addresses and Oral Abstracts Sessions will take place in the Pope Auditorium and 12th Floor Lounge. Coffee breaks will take place in the Plaza Level, which is also the site of the Exhibitor Area.

COFFEE BREAKS/LUNCH
Refreshments (during coffee breaks) are provided to delegates on a complimentary basis; please note that complimentary lunch will not be provided. Visit the Registration Booth for a list of local restaurants in close proximity to Fordham University - Lincoln Center.

INTERNET ACCESS
Wireless Internet access is complimentary at Fordham University - Lincoln Center. Login by selecting the following network: FordhamLC-S. When you open an internet browser, enter the credentials shown here:

Username: iapac    Password: 4intconf
You must then select “Guest” from the drop down menu.

SOCIAL MEDIA
Join the conference’s Twitter conversation: #ICVH2014

SLIDE PRESENTATIONS/ABSTRACTS
Slide presentations will be available at www.iapac.org post-conference. The Program and Abstracts book distributed at registration will also be available in electronic format at www.iapac.org post-conference.

ARCHIVED WEBCAST SESSIONS
Archived webcasts of sessions in the Pope Auditorium will be available at www.iapac.org three weeks post-conference.

QUESTIONS
If you have any questions during the conference, please locate an IAPAC staff member by leaving a message at the Registration Desk. If you have any questions post-conference, please contact Angela Knudson, IAPAC’s Associate Director of Educational Programs, at aknudson@iapac.org.

FORDHAM UNIVERSITY LINCOLN CENTER – 1ST FLOOR
<table>
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<td><strong>MONDAY, MARCH 17, 2014</strong></td>
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<td><strong>TIME</strong></td>
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<td>Plaza Level</td>
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# PROGRAM AT-A-GLANCE

## TUESDAY, MARCH 18, 2014

<table>
<thead>
<tr>
<th>TIME</th>
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<tbody>
<tr>
<td>8:30-9:00 A.M.</td>
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<td>COFFEE BREAK</td>
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<tr>
<td>9:00-10:00 A.M.</td>
<td>Pope Auditorium</td>
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<td>PANEL 2</td>
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<td></td>
<td>Strengthening the HCV Continuum of Care</td>
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<td>Moderator: Mario U. Mondelli, MD, PhD</td>
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<td></td>
<td>Presenter: Fabienne Laraque, MD, MPH</td>
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<td>Discussants: Kosh Agarwal, MD; Jeffrey Kwong, DNP, MPH; ANP-BC; Federico G. Villamil, MD</td>
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<td>10:00-10:30 A.M.</td>
<td>PLENARY 8</td>
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<td>Key Issues in Drug Interactions in the Direct-Acting Antiviral Era</td>
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<td>David J. Back, PhD</td>
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<td>10:30-11:00 A.M.</td>
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<td>Adherence in the Age of HCV Antiviral Therapy</td>
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<td>Jeffrey Weiss, PhD</td>
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<td>11:00-11:15 A.M.</td>
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<td>11:15 A.M.-12:15 P.M.</td>
<td>PANEL 3</td>
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<td>Managing Viral Hepatitis in Primary Health Care Settings and Exploring the Role of Non-Physician Clinicians</td>
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<td>Moderator: Jeffrey Kwong, DNP, MPH, ANP-BC</td>
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<td>Panelist 1: Sherilyn Brinkley, CRNP</td>
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<td>Panelist 2: Donald Gardenier, DNP, FNP-BC</td>
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<td>Panelist 3: Michelle T. Martin, PharmD, BCPS, BCACP</td>
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<td>Panelist 4: Jeffrey Weiss, PhD</td>
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<td>12:15-1:15 P.M.</td>
<td>LUNCH (on your own)</td>
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<td>1:15-2:15 P.M.</td>
<td>disruptions: Session 1: Complicated Cases</td>
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<td>Acute and Chronic HBV/HCV</td>
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<td>Antiviral Therapy Before and After Liver Transplantation</td>
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<td>12th Floor Lounge</td>
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<td>2:30-3:30 P.M.</td>
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<td>Reinfecion: A Limiting Factor for HCV Treatment as Prevention?</td>
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<td>Moderator: Mark R. Nelson, MD</td>
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<td>Presenter: Thomas C.S. Martin, MS, MA, BMBCh, MRCP</td>
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<td>Discussant: Natasha Martin, PhD</td>
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<td>3:30-4:00 P.M.</td>
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<td>Pregnancy and Hepatitis - An Underestimated Clinical Management Issue</td>
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<td>Tram T. Tran, MD</td>
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<td>4:00-4:15 P.M.</td>
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<td>4:15-4:45 P.M.</td>
<td>PLENARY 11</td>
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<td>The Future of HCV in Men who have Sex with Men</td>
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<td>Emma Page, MBBS, MRCP</td>
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<td>4:45-5:15 P.M.</td>
<td>RAPPORTER SESSION AND TOP 2 RATED ABSTRACTS</td>
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<td>Bridging Barriers to Improve Viral Hepatitis Patient Outcomes in Diverse Communities and Populations</td>
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<td>Douglas T. Dieterich, MD</td>
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<td>Mark R. Nelson, MD</td>
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<td>Mario U. Mondelli, MD</td>
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2014 International Conference on Viral Hepatitis
### Oral Abstract Session 1
**Clinical Management**
1:30 P.M. - 2:15 P.M. (Pope Auditorium)
Moderator: Mark R. Nelson, MD

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<td>New All Oral Therapy for Chronic Hepatitis C Virus (HCV): A Cost-Benefit Analysis</td>
<td>Jennifer Orsi presenting</td>
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<td>55</td>
<td>Perceptions of Genetic Testing and Genomic Medicine as Part of Hepatitis C Care among Urban Drug Users</td>
<td>David Perlman presenting</td>
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<td>65</td>
<td>Use of In-Care Viral Load to Assess Care of Hepatitis C in the District of Columbia</td>
<td>Monique Millington presenting</td>
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<td>Hepatitis C Capacity Strengthening Program With Aboriginal Medical Services In Regional Australia</td>
<td>Beth Wilson presenting</td>
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### Oral Abstract Session 2
**Screening and Testing**
1:30 P.M. - 2:15 P.M. (12th Floor Lounge)
Moderator: Yvette Calderon, MD, MS

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<td>49</td>
<td>Does the Addition of HCV Testing to a Rapid HIV Testing Program Impact HIV Test Acceptance? A Randomized Controlled Trial</td>
<td>Sara Rahman presenting</td>
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<td>59</td>
<td>High Yield and Feasibility of HCV Birth Cohort Screening in Two Urban, Academic Emergency Departments</td>
<td>James Galbraith presenting</td>
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<td>63</td>
<td>Economics of Rapid Hepatitis C Screening in Correctional Facilities</td>
<td>John Wong presenting</td>
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### Oral Abstract Session 3
**Coinfection with HIV**
2:30 P.M. - 3:15 P.M. (Pope Auditorium)
Moderator: Benjamin Young, MD, PhD

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<td>Hepatitis C Screening, Retesting, and Treatment Discussion among HIV-Positive Persons in Care, 2011</td>
<td>Bruce Agins presenting</td>
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<td>50</td>
<td>Elevated Mortality Risk in HIV/HCV-Coinfected Patients: Risk Assessment Using the VACS Index</td>
<td>Oluwatoyin Adeyemi presenting</td>
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<td>57</td>
<td>The CORE HCV Cascade: Evaluating Gaps in Hepatitis C Virus (HCV) Evaluation in HIV/HCV Coinfected Patients</td>
<td>Oluwatoyin Adeyemi presenting</td>
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### Oral Abstract Session 4
**Treatment Challenges**
2:30 P.M. - 3:15 P.M. (12th Floor Lounge)
Moderator: Douglas T. Dieterich, MD

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<tr>
<td>54</td>
<td>Patient Management Programs Lead to Improved Adherence for Patients with Hepatitis C using Drug Dual Therapy in Both Retail and Central Pharmacies</td>
<td>Jennifer Orsi presenting on behalf of Francis Staskon</td>
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<td>62</td>
<td>Primary Care-Based Hepatitis C Treatment in the First Generation Triple Therapy Era</td>
<td>Keith M. Sigel presenting</td>
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### TUESDAY, MARCH 18, 2014

### Oral Abstract Session 5
**Top 2 Rated Abstracts**
4:45 P.M. - 5:15 P.M. (Pope Auditorium)

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<td>60</td>
<td>The Role of Social Work in an Interdisciplinary, Hepatitis C Treatment Team</td>
<td>Catherine Amory presenting</td>
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<td>61</td>
<td>HCV Care Cascade Outcomes in a Non-Clinical, Neighborhood-Based Testing and Linkage Program</td>
<td>Stacey Trooskin presenting</td>
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Hepatitis C Screening, Retesting, and Treatment Discussion among HIV-Positive Persons in Care, 2011

Rupali Doshi1, Christopher Wells2, Leah Savitsky2, Tracy Matthews1, Marlene Matosky1, Laura Cheever1, Bruce Agins2 (presenting)

1. Health Resources and Services Administration, Rockville, MD, USA
2. NYS DOH AIDS Institute, New York, NY, USA

Background: National guidelines recommend testing all HIV-positive individuals for HCV upon entry to HIV care, confirmation of HCV viremia among HCV antibody positives (HCVAb+), and retesting HCV antibody negative (HCVAb-) individuals at high risk.

Methods: For 2011, 128 Ryan White HIV clinics self-reported performance measure data for a randomly selected sample of patients with at least 1 visit in each half of the year. HCVAb+ and HCV RNA+ rates were calculated. Frequencies and multivariable logistic regression models with stepwise elimination were calculated for HCV screening, HCV RNA assay for HCVAb+ patients, retesting among HCVAb- persons, and HCV treatment discussion.

Results: 7,966 HIV-positive patients were eligible for HCV screening. Of the eligible patients, 94% were screened for HCV, and 18% were HCVAb+. Of high-risk HCVAb+ patients, 63% were retested. Of the HCV Ab+ patients, 77% were viremic; of HCV RNA+, 86% discussed HCV treatment with the provider. Factors associated with lack of HCV Ab screening included Black (vs. White) race (AOR 1.53), any risk (vs. injection drug use, IDU), private insurance (vs. uninsured) (AOR 1.63), hospital (vs. clinic) (AOR 1.61), other facility (vs. clinic) (AOR 8.73), and all caseload categories (vs. ≥2,000 patients). Factors associated with no HCV RNA testing included other facility (AOR 3.91) and caseload 500-999 (vs. ≥2,000 patients) (AOR 4.05). Factors associated with not retesting high-risk HCVAb- included all insurance types (vs. uninsured), clinic (vs. hospital) (AOR 2.80), and caseload. No factors were independently associated with HCV treatment discussion.

Conclusions: Despite overall high HCV screening rates among retained HIV-positive patients, White race, IDU, uninsured, and hospital clinic were associated with HCV screening. Clinic factors were associated with HCV RNA testing and retesting high-risk HCVAb- persons. Uninsured persons had higher retesting rates than insured persons. Improving HCV viremia confirmation and HCV treatment discussion will be keys to curing HCV among HIV-positive persons.

Does the Addition of HCV Testing to a Rapid HIV Testing Program Impact HIV Test Acceptance? A Randomized Controlled Trial

Yvette Calderon1, Ethan Cowan1, Rajesh Verma2, Mark Iscoe1, Sara Rahman1 (presenting), John Rhee1, Lisa Glass1, Matthew Barbery1, Jason Leider1

1. Albert Einstein College of Medicine, Bronx, NY, USA
2. Jacobi Medical Center, Bronx, NY, USA

Background: Merging two public health screenings, HIV and hepatitis C (HCV), could be crucial in identifying positive patients in high-risk urban settings. A new rapid, point-of-care HCV test opens the possibility of integrating HCV testing into current rapid HIV testing programs. The purpose of this study was to determine how offering HCV testing along with HIV in an urban emergency department (ED) would impact HIV test acceptance.

Methods: We conducted a 2-armed randomized controlled trial on a convenience sample of patients age 18 and above in a Bronx, New York ED. Participants were randomized to an offer of both HIV and HCV testing or HIV testing alone. The primary outcome, HIV test acceptance, was compared between the groups. Secondary outcomes included HIV and HCV prevalence and HCV test acceptance, refusal, risk, and knowledge.

Results: Of 666 eligible patients, 478 agreed to participate. There was no significant difference in HIV test acceptance between the HCV and HIV (91.8%, 224/244) and HIV-only (90.6%, 212/234) groups (p = 0.642); nor were there differences by gender, race, or ethnicity. HCV test acceptance was high (79.9%, 187/234). Majority of participants (76.6%, 366/478) reported at least one HCV risk factor. No participants tested HIV positive, and 1 (0.5%) tested HCV positive. The participants were knowledgeable in recognizing the existence of latent HCV infection (74.3% correctly responded), 70.7% knew alcohol could damage the livers of those with HCV, 66.9% knew HCV could be treated, 43.9% knew there is no HCV vaccine.

Conclusions: Offering rapid HCV testing along with HIV did not significantly impact HIV test acceptance in an urban ED with an existing rapid HIV testing program. Future screening efforts for HCV could be integrated into current HIV testing models without negatively affecting HIV testing rates.
50 Elevated Mortality Risk in HIV/HCV-Coinfected Patients: Risk Assessment Using the VACS Index

Oluwatoyin Adeyemi1 (presenting), Britt Livak2
1. Cook County Health and Hospitals System, Chicago, IL, USA
2. University of Chicago, Chicago, IL, USA

Background: The majority of HIV+/HCV+ patients have not received treatment for HCV, a leading cause of morbidity in HIV patients. The Veterans Aging Cohort Study (VACS) index has been validated as a reliable index to assess 5-year mortality risk in HIV patients, with VACS scores of 20, 50, and 70 indicating 8%, 25%, and 50% 5-year mortality, respectively. We describe correlates of high VACS scores among HIV-positive patients with or without HCV coinfection.

Methods: A cross-sectional electronic chart review of all HIV-positive patients who had >1 clinic in 2011 at the Ruth Rothstein CORE center, Chicago. We calculated VACS scores (includes 7 variables with 0-38 points; Age, CD4 count, HIV-1RNA, hemoglobin, FIB-4, eGFR and Hepatitis C status) and compared VACS scores stratified by HCV status using chi-square tests for categorical variables and Kruskal-Wallis tests for non-normally distributed continuous variables.

Results: There were 4,710 HIV-positive patients with a median age of 47 yrs. 852 (18%) were HCV+. Median CD4 count was 448 and 73% had HIVRNA<75 copies/ml and did not differ by HCV status (p = ns). 74% were male, 62% African American, 23% Hispanic and 12% white. HCV+ were a decade older 54 yrs vs 45 yrs (p <0.001) and less likely to be Hispanic (p <0.001). HCV+ patients were significantly (p <0.0001) more likely to have Hemoglobin<12, FIB-4 >3.25 and GFR<60 compared with HCV- patients. The mean VACS score was higher in HCV+ patients (39.48 vs 21.50 p <.0001) even after HCV+ status was excluded from the total score (34.48 vs 15.23, p < .001). More HCV+ patients had VACS scores of >50 (27% vs 9%; p <0.0001); 11% had VACS>70.

Conclusions: HIV/HCV-coinfected patients have higher mortality risk despite similar CD4 and HIVRNA to HIV+/HCV- patients driven by higher fibrosis scores, older age and anemia. Treating HCV will have the largest impact on mortality risk in coinfected patients.

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51 New All Oral Therapy for Chronic Hepatitis C Virus (HCV): A Cost-Benefit Analysis

Jennifer Orsi1 (presenting), Michael Einodshofer2, Heather Kirkham1, Pheophilus Glover1, Janeen DuChane1
1. Walgreen Co., Deerfield, IL, USA
2. Walgreen Co., Carnegie, PA, USA

Background: New all oral HCV therapies are recognized as having higher cure rates than current standard of care (SOC) treatments. However, the cost-benefit of providing new all oral therapy versus SOC treatment is currently unknown. We undertook a study to examine the financial impact of anticipated all oral therapy for genotype 1 disease and approved all oral therapy for genotypes 2 and 3 disease versus SOC treatments.

Methods: We calculated pharmacy costs of approved drugs using wholesale acquisition costs, assuming a full course of therapy for genotypes 1, 2, and 3 diseases, respectively. Anticipated all oral therapy for genotype 1 was estimated at 1.5 times the cost of all oral therapy for genotype 2. Costs for medical treatment over 14 years were based on published data for four therapeutic endpoints: cured, not cured and no cirrhosis, not cured with cirrhosis, not cured with cirrhosis and end stage liver disease. The study also accounted for the frequency of genotypes 1, 2, and 3 HCV disease within the US population for pooled analysis across genotypes.

Results: Genotype 1 all oral therapy is anticipated to provide overall cost savings of 13% compared to SOC. However, overall costs among approved genotypes 2 and 3 all oral therapy were 14% and 55% higher compared to SOC even with cure rates 17% and 15% higher. After accounting for genotype frequency within the general U.S. population, pooled analysis across genotypes showed a net cost savings of about $1,000 per utilizing member per year for all oral treatment versus SOC.

Conclusions: If our predicted cost of new genotype 1 therapy is accurate, cost savings will only be observed among the anticipated new all oral therapy for genotype 1 disease. However, these savings will provide a net cost savings across genotypes for all oral therapy compared to SOC treatment.
54 Patient Management Programs Lead to Improved Adherence for Patients with Hepatitis C using Drug Dual Therapy in both Retail and Central Pharmacies

Francis Staskon¹ (presenting), Heather Kirkham¹, Janeen DuChane¹, Cindy Moore², Rick Miller², Bobby Clark¹

¹. Walgreen Co., Deerfield, IL, USA
². Walgreen Co., Carnegie, PA, USA

Background: The study investigated the longitudinal effect of pharmacy management programs on adherence rates for patients using dual therapy for the hepatitis C virus (HCV) within retail and central pharmacy channels.

Methods: This was a retrospective study of patients new to HCV therapy who used either retail or central pharmacy channels to obtain their HCV prescriptions. Although the two channels had different operational structures, they provided similar patient management services. The adherence metric was the proportion of days covered (PDC), as endorsed by the Pharmacy Quality Alliance. Active involvement with a patient management program for at least 90 days was examined as a predictor for adherence. Due to the different managed therapy models across channels, propensity scores were used to match patients for the retail analysis, and analysis of covariance was used for the central analysis.

Results: Mean PDC rates for the retail patients improved significantly (16.2%, p <0.0001) for patients managed at least 90 days compared to those less managed. Similarly, patients managed at least 90 days within the central distribution channel had significantly higher adherence rates (29.4%, p <0.0001) than those who did not remain managed. Among retail patients managed at least 90 days, the mean adherence level (77.9%) was comparable (i.e., not significantly different) to that of the central patients (76.8%). The proportion of patients who were adherent to medications (PDC ≥80%) indicated similar significant trends as for mean PDC.

Conclusions: Pharmacy services increased adherence to HCV dual therapy medications in both central and retail pharmacy channels, and reduced the difference in adherence between channels. Previous research has linked medication adherence to reduced viral loads from drug therapy, and improved clinical outcomes. Providing HCV pharmacy management programs that address patient adherence to therapy will likely improve the long-term health outcomes for these patients.

55 Perceptions of Genetic Testing and Genomic Medicine as Part of Hepatitis C Care among Urban Drug Users

David Perlman¹ (presenting), Camila Gelpi-Acosta², Samuel Friedman², Ashly Jordan³, Holly Hagan³

¹. Beth Israel Medical Center, New York, NY, USA
². National Development and Research Institutes, Inc, New York, NY, USA
³. New York University College of Nursing, New York, NY, USA

Background: The promise of genomic medicine is for individual-level genetic information to optimize treatment interventions. Genetic testing (GT) has entered care for the management of hepatitis C virus (HCV) infection (e.g., IL28B testing to inform decision-making regarding interferon-based treatment). There are scant data on how best to integrate GT into HCV care among marginalized populations such as drug users. We explored drug users’ perceptions of GT as they related to HCV care.

Methods: Six focus groups were conducted in New York City with active Drug Users recruited from syringe exchange programs and an HIV clinic between May - June 2012.

Results: Of 34 participants, 44% female; 26% Black; 41% Hispanic; 33% White. 41% reported HIV and 6% reported HCV infection; 6% reported HIV/HCV coinfection. Most had some awareness of GT, though television shows and personal experiences with prison and paternity testing. All welcomed GT if it could improve care for HCV however most had concerns regarding confidentiality and implications for law enforcement. Many were concerned that race-based GT could potentially lead to efficacious treatments being offered to some race/ethnic groups and not others; acceptability was higher when GT was based on individual histories rather than on race/ethnicity. GT-experienced peers were identified as trustworthy sources of information about GT. Participants were generally more comfortable with GT provided in medical care rather than in drug abuse treatment settings, when specifically asked permission and given a clear rationale as to how it would inform their HCV care.

Conclusions: Participants had a general sense of the potential value of GT as part of HCV care, yet concerns regarding confidentiality and discrimination may reduce testing willingness. Safeguards against these risks, providing clear rationales, peer support, and testing in medical settings based on individual histories may be critical in efforts to promote acceptance of GT among drug users.
The CORE HCV Cascade: Evaluating Gaps in Hepatitis C Virus (HCV) Evaluation in HIV/HCV-Coinfected Patients

Oluwatoyin Adeyemi*(presenting), Stephon Effinger*
1. Cook County Health and Hospitals System, Chicago, IL, USA
2. CORE Center, Chicago, IL, USA

Background: The majority of HIV/HCV-coinfected adults have not received HCV treatment for a myriad of reasons, including poor efficacy and tolerability of existing regimens. As HCV therapies rapidly evolve, it is important to understand reasons for incomplete evaluation and develop strategies that close the gaps in the care continuum. We explore factors associated with absence of confirmatory HCV tests in HIV+/HCVAb+ patients.

Methods: Retrospective review of the electronic medical record (EMR) of all HIV+/HCVAb+ patients who had >1 primary care (PC) visit between 1/1/11-12/31/13 at the CORE Center, Chicago. Confirmatory test+ if: (1) HCVRNA (Qual or Quant) or (2) HCV genotype in the EMR.

Results: 269 (24%) of 1,113 HIV+/HCV Ab+ patients had no confirmatory tests (HCV RNA or genotype) in the EMR. 34% were female and 198 (74%) in the high risk birth cohort 1945-1965. Median CD4 was 385 cells/mm³, 33% had CD4 <200 cells/mm³, 58% had undetectable HIV RNA. 22 patients (8%) had HIV RNA>100K. The HCVAb+ result was from years 2002-2005 in 22 patients (8%), years 2006-2011 in 151 patients (55%), year 2012 in 55 patients (20%) and in 38 patients (14%) year 2013. 131 patients (49%) had >1 PC and lab visit in 2013, last visits were in 2012 and 2011 for 24% and 26% of the patients, respectively. Of the 131 patients with a PC visit in 2013, only 38 (29%) had the 1st HCVab+ result in 2013; 50% HCVab+ 2009-2012 and 21% were diagnosed in years 2005-2008. 68 (51%) had CD4 counts >350 cells/mm³ and 92 (69%) had undetectable HIV RNA.

Conclusions: 24% of HCVAb+/HIV-positive patients in our clinic did not have confirmatory HCV tests. Multiple factors contribute to this, including remote HCVAb+ results, uncontrolled HIV, recent HCV diagnosis, and sporadic engagement in care. Initiatives to improve the HCV care continuum through patient and provider education and EMR prompts are being developed for our clinic.

High Yield and Feasibility of HCV Birth Cohort Screening in Two Urban, Academic Emergency Departments

James Galbraith*(presenting), Pamela Green*, Jordan Morgan*, Joel Rodgers*, Ricardo Franco*, James McCarthy*, Kathleen Hoffman*, Jenjung Pan*
1. University of Alabama at Birmingham, Birmingham, AL, USA
2. Memorial Hermann Health System, Houston, TX, USA
3. Memorial Hermann Health System - TMC Campus, Houston, TX, USA

Background: Chronic HCV infection has become an urgent public health challenge, especially for the “baby boomer” birth cohort. The Centers for Disease Control and Prevention (CDC) recommends testing all individuals born 1945 to 1965 without consideration of risk, as risk based testing has proven challenging. The University of Alabama - Birmingham (UAB) and Memorial Hermann Hospital System - Houston (MHHS) are two level-one trauma facilities that began HCV screening in the ED (emergency department) in compliance with CDC recommendations.

Methods: MHHS Study Design: Resident Driven Clinical Quality Improvement project. Participants: All patients age 48-68 who access the ED for care and who are able to opt-out of HCV screening. Interventions: A venous blood sample is processed by an IgG antibody methodology and a two wash immunoassay using chemiluminometric technology for HCV antibody positivity. UAB Study Design: Integrated, opt-out screening by a routine electronic health record nursing questionnaire and automated order. Participants: All “medically/surgically stable” persons ages 48-68 who are unaware of their HCV status. Interventions: A venous blood sample is processed by the Abbott ARCHITECT anti-HCV chemiluminescent assay for HCV reactivity.

Results: MHHS Findings: 3/2013 to 12/2013 - 1,221 patients have been tested with 144 (8.4%) HCV-antibody positive patients identified. Of the positive patients, 70 (48%) were known positive patients, 74 (51%) new positive patients identified. UAB Findings: 9/2013 - 11/2013 - 1,529 self-reported HCV “unaware” patients have been tested with 170 (11.1%) unique newly HCV antibody positive individuals identified. The nursing questionnaire revealed 73% of the unique “baby boomers” presenting to the ED were unaware of their status.

Conclusions: These two projects demonstrate both the feasibility and efficacy of ED-based HCV screening utilizing different screening models.
The Role of Social Work in an Interdisciplinary Hepatitis C Treatment Team

Catherine Amory (presenting), Donald Gardenier, Keith Sigel, Angela Woody, Jeffrey Weiss
Mount Sinai Medical Center, New York, NY, USA

Introduction: Urban underserved persons have significant incidence of chronic Hepatitis C (HCV), but face numerous psychosocial barriers to appropriate HCV care. Mitigation of these barriers fits within a social worker’s skillset, however, literature on the role of social work in an interdisciplinary, HCV treatment team is limited. Our model of social work integration in a grant-funded, primary care-based, HCV treatment program enlists the social worker in provision of pre-treatment evaluation, education, and ongoing treatment support, as well as peer program facilitation and monthly support group co-facilitation.

Description: Case vignettes illustrate the unique role of social work on our team. The first case is of a 56-year-old, homeless, African-American man with severe hearing loss. Upon starting treatment for HCV, he self-reduced his HCV medication dosage. The second case is of a 52-year-old Hispanic woman who refuses to receive blood products as a Jehovah’s Witness and is distrustful of the medical system. She is diagnosed with PTSD and bipolar disorder. The third case is of a 53-year-old Hispanic man with a history of depression, anger management problems, and incarceration. During his previous HCV treatment, he was arrested for a violent altercation.

Lessons Learned: Supportive counseling, cognitive behavioral interventions, and creative problem solving at a systemic level give patients tools to succeed on HCV treatment. Collaboration with community providers and the ability to address concrete needs, including housing and insurance, help patients continue in care. Social work provision of these tasks, as well as facilitation of the peer program and patient support group, help to support the relationship between patients and the entire care team, the key to successful treatment for high-risk, marginalized populations.

Recommendations: The presented model of interdisciplinary collaboration supports treatment completion and warrants further study. Strategies to ensure sustainability are needed.

HCV Care Cascade Outcomes in a Non-Clinical, Neighborhood-Based Testing and Linkage Program

Stacey Trooskin (presenting), Joanna Poceta2, Sophie Feller2, Caitlin Towey2, Annajane Yolken2, Hwajin Lee2, Julia Harvey2, Erin Smith2, Najia Luqman1, Ta-Wanda Preston1, Amy Nunn2

1. Drexel University College of Medicine, Philadelphia, PA, USA
2. Brown University Alpert Medical School, Providence, RI, USA
3. Jefferson Medical College, Philadelphia, PA, USA

Background: Although HIV and HCV infections often cluster in select urban neighborhoods, geographically circumscribed HIV and HCV testing, linkage and retention in care programs are lacking.

Methods: We developed an HIV and HCV screening and linkage to care program in a Philadelphia zipcode with high rates of infection and limited medical services. We tested 1,001 individuals for HIV and HCV between December 12, 2012 and October 1, 2013. HCV screening was performed on a mobile unit using Oraquick© rapid antibody HCV tests. Reflexive confirmatory testing with HCV NAT testing was done via blood draw immediately following a reactive rapid test result. Patients chronically infected with HCV were provided with case management services to achieve linkage to care.

Results: We present preliminary results from our HCV linkage to care cascade. Anti-HCV seroprevalence was 4.2% (n = 42). Among patients with reactive HCV tests, 88% (n = 37) received successful confirmatory testing and 84% (n = 31) of these were chronically infected. Forty-two percent (n = 13) of chronic infections were new HCV diagnoses. No HCV-positive individuals were receiving HCV subspecialty care at the time of testing. Twenty-nine percent (n = 9) of chronically infected individuals were uninsured. Three uninsured patients were lost to care; all others (n = 6) obtained insurance. With aggressive case management, 58% (n = 18) of those chronically infected were linked to subspecialty care; all others are actively engaged in the linkage process. Obtaining a referral for subspecialty care was noted to be a barrier for 35% (n = 10) of individuals who had or obtained a primary care physician. HCV treatment and SVR outcomes are forthcoming.

Conclusions: Geographically focused HCV testing, treatment, and linkage to care programs in non-clinical settings are effective means of identifying new HCV infections and re-engaging individuals with known infection in care. Aggressive case management can help overcome barriers to linking HCV positive individuals to care.
Among 249 detainees screened for serostatus, mean To conduct an economic analysis of rapid HCV testing With 29%-43% of all HCV-infected individuals The emergence of the first generation of direct Of 125 of our patients with GT1 HCV infection, 39 In correctional facilities, rapid HCV screening is After recruitment from the RIDOC facilities, partic- We report treatment initiation and response 18 2014 International Conference on ORAL ABSTRACTS

1. Mount Sinai School of Medicine, New York, NY, USA 2. Mount Sinai Medical Center, New York, NY, USA

Background: The emergence of the first generation of direct acting antiviral medications improved the rates of sustained viral response for genotype 1 (GT1) hepatitis C virus (HCV), at a cost of greater toxicity and treatment complexity. Mitigating these potential barriers to successful treatment in vulnerable populations requires novel HCV treatment para- digms. One such paradigm is primary care-based HCV treat- ment. In this study we present outcomes from our urban, primary care-based HCV treatment program.

Methods: We collected data on demographics, comorbidities, treatment history, and outcomes of 125 patients with GT1 HCV seen in our clinic between August 2011 and April 2013. We compared characteristics of patients who were initiated on HCV treatment to those who were not treated. We then compared the characteristics of treated patients with and without post-treatment viral suppression.

Results: Of 125 of our patients with GT1 HCV infection, 39 were initiated on triple therapy (31%). Patients who were initiated on treatment were younger than those who were not treated (p = 0.002) but otherwise did not differ demographically, or in the severity of their liver fibrosis (p >0.05). Patients who were treated and achieved post-treatment viral suppres- sion (either SVR4, 12 or 24) were less likely to have a history of major depression or substance abuse than patients who did not achieve viral suppression. Post-treatment viral sup- pression was achieved in 16 patients (45%), with relapse noted in 2 patients (6%), viral breakthrough in 6 (16%). Drug toxicity caused 9 (25%) patients to stop treatment early, and 3 (8%) patients were non-adherent.

Conclusions: We report treatment initiation and response rates comparable to studies of other HCV treatment pro- grams, in a patient population with a significant burden of mental illness and previous substance abuse. Our primary care-based model may be a useful model for HCV care in underserved, urban populations.

John Wong1 (presenting), Lauri Bazerman2, Alice Cates3, Irene Kuo3, Ann Kurth4, Emily Patry4, Curt Beckwith5

1. Tufts Medical Center, Boston, MA, USA 2. The Miriam Hospital, Providence, RI, USA 3. George Washington University, Washington, DC, USA 4. New York University, New York, NY, USA 5. Brown University/The Miriam Hospital, Providence, RI, USA

Background: With 29%-43% of all HCV-infected individuals passing through US correctional facilities, rapid HCV screening may provide an opportunity for detection and treatment.

Aim: To conduct an economic analysis of rapid HCV testing conducted as part of a feasibility study within three Rhode Island Department of Corrections (RIDOC) facilities.

Methods: After recruitment from the RIDOC facilities, participants with unknown HCV serostatus provided informed consent, completed a risk assessment questionnaire, viewed a pretest counseling video, and underwent rapid HCV testing. Those with reactive results completed viral load testing for confirmation and persons with viral-positive HCV infection were referred to care. Using recommended standard economic methods, we estimated the staff, test, and transportation costs and calculated costs per HCV case detected.

Results: Among 249 detainees screened for serostatus, mean age was 33 (range 19-58) with 6.4% women, and risk factors included 18% ever injecting, 49% non-professional tattooing or piercing and 71% unprotected sex at last encounter. Rapid HCV screening costs, including test and correctional personnel, ranged from $55-$66 for negative screening tests to $106-$174 for positive screening tests per individual depending on the correctional facility testing site. Based on these results, overall screening costs were $72 per individual, ranging from $59-$76 by site. Of 249 detainees, 25 (10%) had positive HCV rapid screening tests, 23 completed viral load testing, and 15 (65% of 23) had detectable RNA. The cost was $718 per HCV-positive screening test, ranging from $509-$1,292 by site. The cost was $1197 per HCV RNA-posi- tive test ranging from $1,018-$2,583 by site.

Conclusions: In correctional facilities, rapid HCV screening is feasible, identifying the 10% who were HCV antibody-posi- tive and the 6.0% with viral-positive HCV infection. Costs were $718 per antibody-positive and $1197 per RNA-positive HCV infection detected. Future research should examine transition from HCV identification to treatment and cost-effectiveness.
Use of In-Care Viral Load to Assess Care of Hepatitis C in the District of Columbia

Monique Millington (presenting), Amanda Castel, Irene Kuo
George Washington University, Washington, DC, USA

Background: Hepatitis C virus (HCV) prevalence in the United States is estimated at 1.6%. In the District of Columbia, from 2007-2011, 13,520 chronic HCV cases were reported. Treatment options for HCV-infected persons have improved, and measures such as “in-care viral load” (ICVL), previously used to assess HIV treatment outcomes, may be useful in assessing management of HCV. We sought to assess management and outcomes among HCV-infected persons in Washington, DC.

Methods: Utilizing hepatitis surveillance data from 2005-2010, we described characteristics of HCV-infected persons with viral load (VL) measurements, measured mean ICVL and examined percentage of early virological response (EVR) among those with >1 recorded VL, defined as a decrease ≥2 logs within 12 weeks of the initial recorded VL measurement. Multiple logistic regression identified independent characteristics of individuals with a recorded VL. Means for initial and final ICVL were calculated and compared using the Kruskal-Wallis test.

Results: Among 10,874 HCV cases, 52% had at least one reported VL. VL reporting increased between 2005 and 2010. Cases who visited a hepatitis specialist had increased odds of having a reported VL (aOR 3.6, 95%CI: 3.0-4.4). Mean ICVL decreased in the population over time from 5,125,891 IU/mL to 4,424,593 IU/mL, but increased among cases aged 30-39, Whites, Hispanics, and with HIV/HCV coinfection. Cases with HBV/HCV coinfection had the highest mean initial ICVL (13,786,813 IU/mL). Among cases with >1 VL, 15 (0.6%) reached EVR.

Conclusions: Though VL reporting increased and mean VL decreased over time, higher VLs were observed among those with HBV/HCV coinfection, and extremely low rates of EVR were observed. Increasing completeness of reporting and measurement of additional treatment indicators in surveillance will aid in better assessing care and treatment of HCV in Washington, DC.

Hepatitis C Capacity Strengthening Program with Aboriginal Medical Services in Regional Australia

Beth Wilson (presenting), Vanessa Towell
Australasian Society for HIV Medicine, Sydney, Australia

Introduction: The Australasian Society for HIV Medicine (ASHM) has been conducting a hepatitis C virus (HCV) capacity strengthening program with the Bila Muuji Aboriginal Health Services Inc. (Bila Muuji), an alliance of six Aboriginal Medical Services (AMS) in regional New South Wales, Australia.

Description: ASHM used a multifaceted approach to strengthen AMS engagement with hepatitis C screening and management. This approach involved addressing educational needs through introductory and advanced training, localizing a HCV decision making resource and formation of a professional development network. Organizational and clinical management tools were produced including a model of care and an HCV team care plan. In addition, clinical pathway agreements between AMSs and local liver clinics were put in place, including the establishment of nurse-led outreach clinics to improve access to HCV care.

Lessons Learned: The commencement of outreach clinics at two services have provided access to treatment for HCV, where there was previously none. Remaining agreements undergoing approval will initially include regular service visits from the HCV treatment coordinator with the view to establish outreach clinics. Whilst this project has not yet reached the evaluation stage, all training courses have received positive feedback, HCV has been incorporated into health promotion activities and annual health checks, and there has been increased engagement with local liver clinics. These advances have the potential to improve health outcomes through increased access to HCV screening and management for Aboriginal and Torres Strait Islander people in these communities. There were a number of delays and initial difficulties in engaging staff due to competing priorities in Aboriginal health and the consequential impacts on staff availability. These were overcome by tailoring program timelines and activities to staff and service capacity.

Recommendations: An evaluation will be conducted to assess the program’s impact. ASHM will support the continuation of the professional development network to ensure ongoing clinical learning within the context of an evolving treatment landscape.
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International Association of Providers of AIDS Care
Washington, DC, USA
March 17-18, 2014

Letter of Attendance

To Whom It May Concern:

This letter is a confirmation that ____________________________ attended the 2014 International Conference on Viral Hepatitis, held March 17-18, 2014, at Fordham University - Lincoln Center in New York, NY, USA. This two-day conference was jointly sponsored by the International Association of Providers of AIDS Care (IAPAC) and the Icahn School of Medicine at Mount Sinai, in partnership with the International Association for the Study of the Liver (IASL).

Sincerely,

José M. Zuniga, PhD, MPH
President/CEO, IAPAC
Proud partners in delivering clinician education about and expanding access to viral hepatitis treatment.

www.IAPAC.org  www.IASLOnline.com
The 2014 International Conference on Viral Hepatitis is jointly sponsored by the International Association of Providers of AIDS Care (IAPAC) and the Icahn School of Medicine at Mount Sinai, in partnership with the International Association for the Study of the Liver (IASL). We wish to express our gratitude to the institutional and commercial supporters whose generosity has made this conference possible.